ASSOCIATION OF COMMUNITY CANCER CENTERS

MULTIDISCIPLINARY APPROACHES TO CARING FOR GERIATRIC PATIENTS WITH CANCER
The leading education and advocacy organization for the multidisciplinary cancer team.
Multidisciplinary Membership

- Billers & Coders
- Financial Advocates
- Hospital President/CEO/COO/VPs
- Medical Directors
- Nurses & Nurse Practitioners
- Oncology Service Line Directors
- Program & Practice Administrators
- Pharmacists
- Medical, Radiation, & Surgical Oncologists
- Social Workers

ACCC is a powerful network of more than 25,000 multidisciplinary practitioners and 2,000 cancer programs and practices nationwide.

ACCC members work in every care delivery setting, from private practices to hospital-based cancer programs, large healthcare systems, and major academic centers.
GOALS

• Identify Barriers and Best Practices
• Improve Patient Experience, Access to Care, Shared Decision Making, Multidisciplinary Coordination
• Give ACCC members models and tools to use to enhance Geriatric Care within their community
Survey Highlights

• 332 responses
Q7 Please estimate the average number of older adults (age 65 and older) seen at your cancer clinic or program each month.

- Less than 50: 13.06%
- Between 50 and 100: 25.00%
- Between 101 and 500: 42.54%
- Over 500: 19.40%
Q9 Have any oncology providers or other clinical staff received a board certification in gerontology/geriatrics or taken specialty training/have expertise in gerontology/geriatrics (may include research interests)?

- Yes: 32.10%
- No: 36.16%
- Not sure: 29.89%
- Other (please specify): 1.85%

Total: 100%
95% strongly agree or agree that their older adult patients would benefit from a comprehensive geriatric assessment (CGA) in addition to the oncology assessment, prior to starting treatment. [Q12, n= 255]

Yet only 17% routinely conduct a CGA [Q15, n=253]
Geriatric Assessment & Evaluating Older Adults

- **74%** of respondents *either don’t use screening tools or plan to incorporate them* in their programs in the near future. [Q13, n= 243]

- Respondents will conduct **additional targeted assessments** with older adult patients when patients [Q16, n=207]:
  - Present with signs of depression or cognitive impairment (20%)
  - Have significant/multiple comorbidities (16%)
  - Advanced, high risk and metastatic patients (8%)
Top 3 Barriers to Conducting CGA

- Time constraints (60%)
- Limited familiarity with available validated geriatric screening/assessment tools (49%)
- Limited personnel (46%)
Provider-Patient Communication about Treatment Goals, Options & Decision-Making

- **Less than 10%** of respondents **utilize patient decision-making aids or tools** [Q31, n=205].

- When **efficacy and safety** of a treatment are **similar**, respondents cited these **top 3 factors** for influencing **mode of treatment administration** [Q33, n=195] :
  - Patient preference (81%)
  - Patient medication management ability and adherence (77%)
  - Availability of caregiver support (77%)
Clinical Trials

- The **majority (62%)** of respondents are **not aware of efforts** in place or planned at their cancer program **to increase clinical trial participation among older adults** [Q34, n=206].

- **45% of respondents** say they do look at the **age range of trial participants** when reviewing clinical literature or the PI. [Q35, n=203]
  - **75% of physicians**
44% of respondents’ cancer programs have a formal process for transitioning patients to post-treatment and survivorship care [Q39, n=206].

End-of-life planning is most often addressed through the patient completion of advance directives. To address end of life planning these approaches were most cited [Q41, n=203]:

- We have patients complete advance life directives (61%).
- We routinely discuss end of life planning with advanced cancer patients (52%).
- We discuss end-of-life planning when the patient has exhausted all treatment options (48%).
Respondents cited these challenges to palliative care referral [Q40, n = 202]:

- Patients don’t understand the benefits of palliative care and/or think it’s the same as hospice care (68%)
- Palliative care is thought of late in the treatment experience (55%)
- Physicians don’t understand the benefits of palliative care. (40%)
- There are not enough palliative care trained-staff. (32%)
Respondents rely primarily on clinician-dependent mechanisms for assessing older patients for geriatric related health concerns.

<table>
<thead>
<tr>
<th>Evaluation Category</th>
<th>Top 3 Cited Techniques &amp; Tools</th>
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<tbody>
<tr>
<td>Fitness for treatment</td>
<td>1. <strong>ECOG/Karnofsky performance status</strong> (76%)</td>
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<td></td>
<td>2. Evaluation of ADLs (48%)</td>
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<td>3. Review notes in medical record (36%)</td>
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<td>Cognitive status</td>
<td>1. <strong>Asking simple questions to assess orientation</strong> (54%)</td>
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<td>2. Mini-mental status exam (36%)</td>
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<td>3. Don’t formally evaluate cognition with older patients (27%)</td>
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<tr>
<td>Psychological status/Depression screening</td>
<td>1. <strong>NCCN distress thermometer</strong> (55%)</td>
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<td></td>
<td>2. The patient interview (36%)</td>
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<td></td>
<td>3. Ask the patient directly if depressed (34%)</td>
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<tr>
<td>Comorbidities</td>
<td>1. <strong>History and physical exam by oncologist</strong> (68%)</td>
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<tr>
<td></td>
<td>2. Check EMR for comorbidities (55%)</td>
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<td></td>
<td>3. PCP notes (51%)</td>
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<td>Toxicity risk for proposed chemotherapy</td>
<td>1. <strong>CARG toxicity calculator</strong> (36%)</td>
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<td>2. CRASH (23%)</td>
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Techniques for Evaluating Older Adults

- **Prior to starting treatment**, respondents most cited **evaluating these 5 factors** in their older adult patients [Q25, n=208]:
  - Risk of falls (74%)
  - Evaluation of support system/caregivers (73.6%)
  - Transportation barriers (73.1%)
  - Polypharmacy/medication assessment (70.1%)
  - Financial toxicity (65%)

- A minority of respondents have **health information technology (HIT)** that supports **screening patients for high risk medications** [Q27, n=211]:
  - 36% of respondents indicated have access to HIT to identify *medication/disease contraindications*
  - 26% of respondents indicated have access to HIT to identify *medication adverse events*
  - 20% of respondents indicated have access to HIT to identify *treatment risks that outweigh benefits*
Physicians n=38

- 90% of physician respondents believe in the benefits of CGA, 30% routinely conduct a CGA.
- Approximately 50% indicated they don’t use screening tools in their programs to identify patients for CGA.
- 30% indicated they use other tools or screeners for specific health concerns e.g. depression.
- Of the respondents who indicated using screening tools listed:
  - 10% indicated they were always comfortable with the results.
  - 24% almost always comfortable with the results.
  - 14% sometimes comfortable with the results.
• 63% of physicians are familiar with the Shared Decision-Making Model, 50% indicate they are confident in using the model [Q29, n=28]
Physicians

- Physicians indicated they evaluate patients pre-treatment for most often for [Q25, n=28]:
  - Polypharmacy/medication assessment (89%)
  - Patients’ medication management skills (71%)
  - Risk of falls (71%)
  - Evaluation of support system/caregivers (68%)
  - Transportation barriers (68%)
  - Treatment adherence barriers (64%)
Examples of Effective Practices in the Care of Older Adults with Cancer

<table>
<thead>
<tr>
<th>Practices &amp; Processes</th>
<th>HCP Training &amp; Patient Education</th>
<th>Other</th>
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<tbody>
<tr>
<td>• Nurse managed care coordination with off site care</td>
<td>• In-services, seminars, conferences</td>
<td>• Validated Screening/Assessment Tools:</td>
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<tr>
<td>• Advance practitioner run chemotherapy preparation visits with screening tools</td>
<td>• Geriatric Oncology led CME programs for interdisciplinary staff</td>
<td>• PHQ2,7,9 (depression severity measures)</td>
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<tr>
<td>• Neuropsychologist and outpatient palliative care team/programs</td>
<td>• Lecture series/Grand Rounds presentations</td>
<td>• FACT-G (QOL questionnaire),</td>
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<td>• Dedicated geriatric oncology clinic/evaluation center</td>
<td>• Video and online learning &amp; training courses</td>
<td>• Mini-nutritional assessment</td>
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<td>• Part time/on call supportive care staff (social work, nutrition, palliative etc.)</td>
<td>• Geriatric Communication Skills training</td>
<td>• St. Louis Univ Mental Status assessment tool for geriatric pop (SLUMS)</td>
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<td>• Survivorship care plans and programs (with nurse navigator)</td>
<td>• Annual competency testing</td>
<td>• Memberships: NICHE (Nurses Improving Care for Healthcare System Elders)</td>
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<td>• SDM integrated into chemo consent</td>
<td>• Monthly multidisciplinary geriatric case conferences</td>
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<td></td>
<td>• Patient chemotherapy teaching sessions</td>
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<td>• Patient oral chemo compliance program with follow-up</td>
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Takeaways

• Geriatric expertise and resources are scarce
• Although validated tools for geriatric assessment in oncology care exist, they are not yet routinely utilized by providers
• Physicians may drive care, but it is essential for the multidisciplinary team to be engaged and knowledgeable
• No consensus on definition or metrics for quality & value
Questions?

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